KHPA Reduced Resource Package

Staff Recommendations

Reduced Resource	All Funds	State Funds
Professional Rate Leveling	($2,800,000)	($1,000,000)
Streamlining Prior Authorization in Medicaid	($952,000)	($243,000)
Mental Health Pharmacy Management	($2,000,000)	($800,000)
Total	($5,752,000)	($2,043,000)

Reduced Resource Package: *Professional Rate Leveling*

Description: Physician payment rates increased in 2006 using proceeds from the hospital provider assessment are currently being reimbursed at 83% of the Medicare Non Facility Physician Fee Schedule. This proposal would level the rate for nearly all remaining professional services at 83% of Medicare. This would be accomplished by reducing rates currently paying at more than 83% of Medicare and by raising other rates currently paying at less than 83% of Medicare. Rates for basic primary care which currently pay above the 83% target will be held harmless and not included in the rate leveling process.

Background: Rates for professional services in Kansas Medicaid have not been systematically reviewed to standardize rate setting practice and policy. Historically, rates were determined on a service by service basis based on inquiries from providers or policy makers, to re-evaluate prior reduction activities, or because of federal mandates.

Hospital and outpatient rates currently average 84% of Medicare. Professional rates increased in 2006 using funds from the hospital assessment program are reimbursed at 83% of Medicare (down from the original target of 87% due to subsequent increases in Medicare payments). However, not all professional rates were affected by those increases: some that were below the original 87% target were not raised, and all that exceeded the 87% target were left alone. As a result, professional rates now range from 10% to 800% of Medicare's Physician Fee Schedule. This proposal would level nearly all professional fees at 83% of the Medicare Non-Facility Physician Fee Schedule -- the higher of the two alternative Medicare schedules. Basic primary care service rates would not be changed, leaving some above the new 83% target.

The result would be a more equitable and rationale payment policy for professional services, a uniform payment standard for services added to the program in the future, and a more equitable basis for new policy initiatives, such as the payment-related components of a medical home.

Population Impacted: KHPA analyzed the populations impacted based on claims paid between April and June 2008. Of the professional services identified for rate leveling, 59% were provided to people with disabilities, 20% were provided to the General Assistance or MediKan population, and 14% were provided to families. Overall, 89% of the services were provided to adults.

Budget Impact: This proposal would result in a leveling of professional services at 83% of Medicare rates for FY 2011.

PCA Code	All Funds	SGF	Fee Fund
	($2,800,000)	($1,000,000)	

Considerations: State plan amendments may be required. Depending on how many exceptions and how the reductions are applied across service categories, the amount of system work will vary.

Staff Recommendation: Include in KHPA's budget recommendations to the Governor.

Board Action:

Reduced Resource Package: Streamlining Prior Authorization in Medicaid

Description: KHPA would implement an enhanced prior authorization (PA) system to increase the automation of and expansion of the decision rules used to evaluate requests for medical services.

Background: The proposal would enhance and automate the existing PA system. Kansas Medicaid currently operates a manual PA system for medical services and is building an automated process for pharmacy. Manual PA requests are submitted by mail or fax and simple requests are reviewed by nurses. Pharmacists review all prescription requests that fall outside of established criteria. With nearly 6,000 PA requests annually (~16/day), the review process requires a large investment of staff time.

Automated PA programs intercept inappropriate claims during the point of sale transaction, while allowing claims that meet evidence-based guidelines to be paid and filled. The criteria for approving the PA requests can be programmed into an electronic system, increasing efficiency at the pharmacy and in the Medicaid program. Approximately 80% of PA requests are approved after evaluating the information submitted by providers with established clinical criteria. The pharmacists and other clinical personnel that now review that information could spend their time more productively managing other aspects of the Medicaid drug program. Additionally, electronic clinical and financial editing would allow Medicaid to expand the number of claims reviewed through the system without an undue administrative burden on providers or the state. This added capacity would allow the state to expand the number of drug classes on the preferred drug list from the current 34 classes. Since implementing an automated PA system, Missouri has expanded from 12 to 100 drug classes.

To implement enhanced PA, KHPA would issue a request for proposals for a data system and customer service support. The contractor would introduce a system to interact with the Medicaid Management Information System. The system would query patients' medical and pharmacy claims history in real time to determine the appropriateness of therapies based on established best practices criteria. Physicians and pharmacists will receive real time notification, generally within seconds, of PA denials or requirements for additional information allowing them to select more appropriate therapy at the point of care.

Population Impacted: This option would be implemented statewide and would affect the entire Medicaid and HealthWave population.

Budget Impact: The proposal would save funds in FY 2011 by putting PA criteria in place sooner. To estimate the impact of shortening the process for approving PA criteria, KHPA identified several drugs and drug classes that have been identified for PA and completed the rules process. Based on the last three PA regulations that have been implemented, putting them

in place four months earlier would have saved an additional $82,000. These three drugs saved a total of $328,000 during FY 2008, but took six months to be implemented.

We also compared savings if the approval process and implementation process in the payment system was faster using an automated PA system. For the proton pump inhibitor (PPI) drug class, it took 33 months from approval of the regulation to implementation in the payment system. Once the PA was implemented in February 2008, prior authorization of PPIs saved $70,000 each month. If the PA could have been implemented in 12 months, the state could have saved $1,470,000 more with the PA applied for 21 additional months. This is as an example of implementing PA criteria faster across additional drug classes.

The proposal would use savings generated from automating prior authorizations to pay for the additional contract costs needed to acquire an enhanced PA system. Based on preliminary conversations with vendors, the cost of implementing a system is between $500,000 and $750,000, with similar annual operating costs.

PCA Code	All Funds	SGF	Fee Fund
35000 (Medicaid assistance savings	($1,552,000)	($543,000)	
34200 (contract cost)	$600,000	$300,000	
Total Impact	($952,000)	($243,000)	

Considerations: Accelerating the procurement process to run during FY 2010 in tandem with the legislative review of the budget allows KHPA to achieve savings from enhanced PA in FY 2011 that will more than offset the cost of implementation. In future years, there would be additional cost savings from the expanded PDL and increased supplemental drug rebates associated with the expanded PDL.

The development of an enhanced PA system may take six to nine months to implement. The request for proposal process alone would take several months and any contract would require approval by the state information technology office and the Centers for Medicare and Medicaid Services (CMS). The system enhancement would require careful integration with the existing MMIS and how claims are processed.

Staff Recommendation: Include in KHPA budget recommendations to the Governor.

Board Action:

Reduced Resource Package: *Initiate mental health pharmacy management*

Description: This proposal would enable the use of standard pharmacy management tools to implement safety edits and create a preferred drug list (PDL) for mental health drugs based on the recommendations of an advisory committee. This would result in improved safety and cost-effectiveness in the use of mental health drugs.

Background: State law currently prohibits management of mental health prescription drugs dispensed under Medicaid. With this proposal, that prohibition would be rescinded and KHPA will use the newly created Mental Health Prescription Drug Advisory Committee (MHPDAC) to recommend appropriate medically-indicated management of mental health drugs reimbursed through the Medicaid program. These tools comprise industry-standard management of mental health prescription drugs, with the added protections and transparency of the Advisory Committee and Medicaid's unique regulatory process.

Over the past several years mental health drugs have been the highest drug expenditure by class of medications and the most-prescribed drugs by volume in the Medicaid program. This has led to expenditure growth in pharmacy services that exceeds growth in other services. Expenditures for mental health drugs increased from the previous fiscal year by more than $4.0 million in FY 2007. In addition to the increase in cost, serious concerns about safety have arisen, especially in children. An analysis of KHPA claims data revealed that in FY 2008, 576 children less than 18 years of age were prescribed 2 or more atypical antipsychotics simultaneously and 851 children under age 18 were prescribed 5 or more psychotropic medications within one 90 day period. Many of these newer drugs have recently been associated with negative side effects. A large scale meta-analysis of 150 scientific trials found that the newer generation of anti-psychotics carried no clear advantage in effectiveness in the treatment of schizophrenia, were associated with significant new risks, and in comparison to the older drugs did not improve on the pattern of side effects observed in older drugs.

In order to use the expertise of mental health providers and consumers in Kansas to better manage these prescription drugs, the KHPA has established the Mental Health Prescription Drug Advisory Committee. Currently the MHPDAC is reviewing safety issues in the Medicaid program and setting an agenda for increased education for providers. In FY 2011, KHPA would take advantage of the expertise on this committee to begin to establish a PDL for mental health drugs and craft prior authorization criteria for some drugs to ensure safe use. If able to implement a PDL by July of 2010, the KHPA proposal would have an expected savings of $2.0 million, including $611,800 from the State General Fund in FY 2011.

Population Impacted: This proposal would positively affect persons using mental health drugs as well as assist those professionals who administer these drugs through the provision of feedback which would improve both safety and cost-effectiveness.

Budget Impact: The savings in FY 2011 is based on the assumption that the MHPDAC would select only antidepressants and stimulants for inclusion on a PDL in FY 2011.

PCA Code	All Funds	SGF	Fee Fund
35000	($2,000,000)	($800,000)	

Considerations: No state plan amendments would be required. The existing state statute prohibiting management of mental health drugs in Medicaid would need to be repealed or amended. Conforming changes in state regulation may also be necessary.

Staff Recommendation: Include in KHPA's budget recommendations to the Governor.

Board Action:

Reduced Resource Package: *Emergency Room Co-Payments*

Description: This proposal would establish a $25 co-payment on individuals who receive services in the emergency room for medical treatment of a non-emergent condition.

Background: Emergency rooms (ER) are often accessed by individuals for medical treatment for issues that are not actual emergencies. Data indicates an average of 19 percent of ER care is non-emergent. Many of the rural hospitals have high non-emergent ratios due to the lack of alternative health care providers, especially for evenings and weekends. Hospitals have responded to this by opening or supporting clinics in proximity to some emergency rooms in an effort to divert individuals from seeking care for non-emergent conditions somewhere other than emergency rooms. The Deficit Reduction Act (DRA) of 2005 amended the Social Security Act to permit states more flexibility in imposing copayments. Under DRA provisions, states can impose copayments, even on usually exempt populations like children, when beneficiaries in those population groups receive non-emergency services at an ER. However, states are still bound by the nominal copayment rules found in Section 1916A of the Social Security Act. These rules are tied to certain income level guidelines and specify an aggregate total cost sharing cap of 5% of the family income. For beneficiaries with incomes below 100% of the Federal Poverty Level the copayment amount for each service must be nominal. For higher incomes the copayments can be 10% or 20% of the total cost of the services. Under the DRA states can choose to allow providers to deny services if copayments are not made.

Additional requirements should copayments be imposed include:

- An alternate non-emergency Medicaid provider who can provide the service must actually be available and accessible
- The hospital must tell the patient, following an appropriate medical screening examination and before providing the non-emergency service, that a copayment will be imposed and may be collected before service provision
- The hospital must also provide information about the alternate provider, including name and location, and that the provider can provide the service without a copayment requirement
- The provider must also provide a referral to coordinate scheduling with the alternate provider

Data collected by the Kaiser Commission in October 2006, indicated 19 states were requiring copayments and most of those were charging $6 or less.

Population Impacted: There are limitations on who can be charged a co-payment in emergency rooms. Section 1916 of the Social Security Act excludes the imposition of copayments on certain groups. Examples are:

- Individuals under 18 years of age who are in foster care or individuals to whom adoption or foster care assistance is made available
- Pregnant women, if the services relate to the pregnancy or other conditions that might complicate the pregnancy
- Any terminally ill individual receiving hospice care
- Persons residing in institutional settings
- Women who are receiving medical assistance by virtue of the application of breast or cervical cancer provisions

Budget Impact: This proposal would entail assessing a $25 co-payment to persons seeking non-emergent care in hospital emergency rooms. Calculations are for FY 2011.

PCA Code	All Funds	SGF	Fee Fund
35000	($93,000)	($33,015)	

Calculations were based on a review of claims data that removed categories where copayments would not apply and included estimated reductions for lack of alternate medical/treatment settings and diversions in avoidance of the imposed copayment.

Considerations: Policy would have to be developed that is consistent with Emergency Medical Treatment and Active Labor Act (EMTALA), the Social Security Act and the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986 provisions.

Co-payments cannot be applied to some services such as preventive care and family planning services and supplies. Conforming changes in the Medicaid state plan may be necessary. No change in regulation is expected.

Staff Recommendation: Do not include in KHPA's budget recommendations to the Governor. Savings are nominal, the administrative burden is high, and the impact on consumer behavior and health is uncertain.

Board Action:

Reduced Resource Package: *Increase HealthWave Premiums*

Description: The monthly premium for HealthWave families would be increased by either $10 or $20 per family. The resulting premiums would be between $30 per month and $50 per month depending on the family size and income.

Background: HealthWave is a blended program for certain Children's Health Insurance Program (CHIP – Title XXI) and Medicaid (Title XIX) eligible individuals. CHIP provides free or low cost health insurance coverage to children under the age of nineteen, with family income too high to qualify for Medicaid but less than 200 percent of the federal poverty level (FPL), and who are not covered by state employee health insurance or other private health.

SCHIP coverage is to be expanded to 250% of FPL in January 2010. Premiums for families between 200% and 250% of FPL will be set at $50 to $75 per month.

Each year, Title XIX/Medicaid provides services to 79,916 different children under the age of six (39,941 through HealthConnect or HealthWave) and 113,519 who are children between the ages of six and eighteen (55,652 through HealthConnect or HealthWave).

Each year, Title XXI/CHIP provides services to 12,922 children under the age of six and 38,251 children between the ages of six and eighteen, all served by HealthWave managed care organizations.

The maximum level at which premiums can be assessed is 5% of the current FPL. For a family of three with monthly income at 150% of the federal poverty level, the maximum allowable premium would be about $130 per month. Premiums are shared with the federal government in the same proportion as the Federal match rate, approximately 72% Federal and 28% State. Current HealthWave premiums are set at $20 and $30 per month per family.

Population Impacted: Premiums only can be assessed on families with incomes above 150% of the FPL, so only a portion of CHIP HealthWave families would be affected.

Budget Impact: This proposal would increase current premiums by either $10 or $20 per month as a revenue enhancement for SFY2011. Calculations took into account an expected number of children who would drop from the rolls as a result of an increase in premiums. With an increase in the monthly family premium of $10, expectations are 1,029 children in premium-paying families will either not enroll or not renew coverage. With an increase of $20 per month, expectations are 3,262 children will either not enroll or not renew coverage.

Increase	PCA Code	All Funds	SGF
$10	36101	($1,727,880)	($350,226)
$20	36101	($5,477,498)	($1,419,941)

Considerations: The premium amounts are described in the SCHIP state plan and would require a plan amendment. Based on prior experience with increasing the premiums, KHPA knows that higher premiums will reduce the level of participation in SCHIP. Source documents used to determine rates of reduction were Inquiry 43, Winter 2006/2007 "Effects of Premium Increases on Enrollment in SCHIP: Findings for Three States and CBPP study: 07/07/2005 "The Effect of Increased Cost-Sharing in Medicaid."

Staff Recommendation: Do not include in KHPA's budget recommendations to the Governor. The State is set to expand coverage in SCHIP to children up to 250% of poverty, and just received a five-year $40 million grant to improve outreach and modernize the enrollment process. These two efforts will help to address a sharp increase in the number of uninsured Kansas children in 2008. Increasing premiums would add to the number of uninsured children, potentially undermining the gains to be made through the expansion and newly-funded outreach and enrollment effort.

Board Action: